Viral Meningitis/Encephalitis/Meningoencephalitis Report Form

If you have any questions concerning the information requested on this form, please contact the Office of Epidemiology at (801) 538-6191

Patient Information

Last Name _____ First Name _____

Date of Birth ___/___/_____ Age _____ Sex ☐ Male ☐ Female **Date of Report** ___/___/___

Address _____ City _____ County _____

State _____ Zip Code _____ Telephone Home (_____)_____ Work (_____)_____

Race ☐ White ☐ Black ☐ Am Indian/Alaskan ☐ Asian ☐ Other ☐ Unknown Hispanic ☐ Yes ☐ No ☐ Unknown

Clinical Information

Hospitalized? ☐ Yes ☐ No Did patient die of this illness? ☐ Yes ☐ No ☐ Unknown

Hospital Name _____ City _____ State _____

Admission Date ___/___/___ Date of Onset ___/___/___ Date of First Neurologic Symptom ___/___/___

Current Diagnosis: ☐ Encephalitis ☐ Meningoencephalitis ☐ Meningitis ☐ Other _____

Medical History

Has the patient been vaccinated for or had a prior history of:

☐ Yellow Fever ☐ Japanese Encephalitis ☐ Dengue Fever ☐ St. Louis Encephalitis

☐ Other arbovirus or flavivirus (please specify) _____

Specimens Collected	Date Collected	Type of Test	Result	Etiologic Agent
CSF				
Serum (Acute)				
Serum (Convalescent)				
Other (Specify)_____				

Travel History

Travel during the two (2) months before onset of illness

Date	City	State	Country

Requesting Physician

Last Name _____ First Name _____

Work Address _____ State _____ Zip Code _____

Telephone Numbers Work (_____)_____ Cell (_____)_____ Pager (_____)_____

Submitted by: _____ Agency: _____ Phone: (_____)_____

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